PHARMACY REQUEST FOR AN ADJUSTMENT

ND DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 640 (Rev. 06-2002)

INSTRUCTIONS: Use one form for each prescription.

(1) Reason for Request:

☐ A. Underpayment ☐ C. Overpayment ☐ E. Other _____

☐ B. No Payment ☐ D. Corrected Billing _____

(2) Provider's Name:			(4) Recipient Indentification:
Provider's Address:			I.D. Number:
City:	State:	Zip Code:	Patient's Name:
(3) Provider's Number:			Case Number:
			Birth Date:

(5) Recipient's Residence:	(6) Remittance Advice Date:	(9) Control Number: (From Remittance Advice)
☐ SNF ☐ Custodial Care ☐ ICF ☐ Swing Bed ☐ ICF/MR ☐ Private Residence	(7) Authorization Number: (8) Prescribing Doctor's Name or Number:	

FOR EACH BLOCK, DETAIL SPECIFICS AS ON AUTHORIZATION FORM & REMITTANCE ADVICE

(10) Date of Service	(11) Rx Number	(12) Rx Date	(13) Drug Name, Conc. & Mfg.	(14) NDC Number	(15) Quantity (Metric)	(16) Bill Amount	(17) Paid Amount

(18) State Use Only	(19) Explanation/Remarks: (Corrected information is to be entered in this space. Be complete and descriptive.)

(20) Mail To:
Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505

Copy: Retained by Pharmacy

(21) Provider's Signature:

Date:

Telephone Number: